STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 04/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 27, 2019 through April 1, 2019. The deficiency contained in this report is based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred forty nine (149). The survey sample totaled eighteen (18). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; Pressure Ulcer - sore area of skin that develops when the blood supply to it is cut off due to pressure; TAR (Treatment Administration Record) - list of daily/weekly/monthly treatments performed.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		5/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/09/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 842	Continued From page 1 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments ; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 2 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the resident's medical records were complete and accurate by not including all components of a physician's order for weekly skin evaluation coding for one (R4) out of three residents reviewed for alleged abuse. Findings include: Review of R4's clinical record revealed: 11/27/18 - 3/22/19 - A physician's order called for a "Weekly Skin Evaluation: Nurse to initial & code appropriately. 0=No Skin Impairment, 1=Pre-Existing Area, 2=New Area (proceed to wound assessment if pressure ulcer/non-pressure ulcer)" January - March 2019 TAR reveals weekly skin checks are performed, by a check mark and nurse's initials. No coding is recorded. During an interview on 3/29/19 at 10:30 AM E2 (interim DON) explained that the option to code the assessment is missing in their computer program. The system has not been set to trigger this response. R4 did have wounds being treated at this time. Progress notes were available from nursing on treatment and checks of these wounds, but not the weekly skin evaluation coding that was ordered.	F 842	1. Resident # R4 no longer resides at the facility; therefore no corrective action can be taken. A Root Cause Analysis (see attached) was completed to determine etiology of deficient practice. 2. A clinical record audit (see attached) was conducted by the QA nurse on all current residents residing in the facility to ensure a weekly skin evaluation order is in place on the TAR and reflecting the appropriate coding. All non-compliant items were corrected at the time of the audit. 3. All skin checks will be systematically scheduled on the evening shift in PCC(EMR). One consistent shift will prevent PCC coding documentation from being affected. The licensed staff will be educated by the staff development RN or designee on the new skin evaluation template reflecting the pre-selected shift. 4. All new admissions and readmissions will be reviewed daily by the Director of Nursing or designee during the clinical morning meeting. The review will ensure that the weekly skin evaluation orders along with the correct supplemental coding are activated in the system and the	

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F 842	Continued From page 3 These findings were reviewed with E1 (NHA) and E2 (interim DON) at exit conference on 4/1/19 at 1:45 PM.	F 842	preselected shift is accurate. The facility's unit managers (3) will conduct random audits of weekly skin evaluation orders on the TAR and the appropriate coding on 5 residents weekly x 4 until 100% compliance is achieved x 3; then 5 residents monthly x 2 until 100% compliance is achieved x 3 and sustained. Findings will be reviewed in the facility's monthly QAPI meeting x 3 to ensure sustained compliance.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation and Health Center **DATE SURVEY COMPLETED: April 1, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from March 27, 2019 through April 1, 2019. The deficiency contained in this report is based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred forty nine (149). The survey sample totaled eighteen (18).	Cross refer CMS 2567-L F 842	5/30/19
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed April 1, 2019: F842		

Provider's Signature [signature] Title NHA Date 4/10/19